

GLENVILLE-EMMONS INDEPENDENT SCHOOL # 2886

2023-2024 SCHOOL YEAR

PRESCRIPTION MEDICATION REQUEST AND AUTHORIZATION

NAME: _____ DOB: _____
Last First Middle

FOR THE DOCTOR

1. Medication _____ Method of Administering Medication _____
Dosage _____ Time to be given in school _____
2. Diagnosis and medical reason for this medication: _____

3. Possible side effect of this medication _____

4. Final date for medication _____
5. Please supply the parent with two prescriptions: one for the home and one for the school. Without a pharmacy container matching the above order we cannot give the student his/her medication.

Dr. Signature: _____ Date: _____

Address: _____ Phone Number: _____

FOR THE PARENTS

1. We request personnel at School to give the above child medication.
2. **We understand that the Glenville-Emmons School #2886 is NOT responsible if the child has a reaction from the medication.**
3. We will provide the school with the medication in a prescription container (not pill boxes or old prescription containers).
4. We will notify the school if there is a change in the medication with a new medication request and authorization.
5. We will also notify the school if the medication is discontinued before the time stated in the Physician's order.

Parent's signature: _____ Date: _____